Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

JOHN MANNING REGAN, for himself and for all others similarly situated,

Petitioner,

v.

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE and METROPOLITAN LIFE INSURANCE CO., and UNITED HEALTHCARE CORPORATION,

Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of the State of New York, Appellate Division, Fourth Judicial Department

PETITION FOR WRIT OF CERTIORARI AND APPENDIX

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RULE 14

(a) Questions Presented

I.

Title 42 §1395 p. of the United States Code subparagraph (d), establishes an initial enrollment period for the Medicare program for individuals becoming eligible for Medicare benefits when they attain age 65. Its duration is seven months.

Title 42 §1395 q. of the United States Code, subparagraph (a), establishes the time when coverage under Medicare B commences in relation to the time enrollment occurs during the initial enrollment period. The commencement of coverage under Medicare B can vary as much as six months depending on the month when enrollment occurs during the initial enrollment period.

These federal statutes define and control the meaning of Medicare enrollment "when first eligible" at age 65.

Question:

Can a State establish a group health insurance plan which mandates participants' enrollment in Medicare B "when eligible for primary Medicare coverage", and which then *assumes*, without any additional notice, or informed consent from such participants, that Medicare B coverage has commenced for them as of the very earliest possible date under 42 U.S.C. 1395 q. in order to terminate its health insurance primary medical coverage at that earliest possible time, or, do these federal statutes:

(1) Under the Supremacy Clause of the U. S. Constitution, bar any state authorized health plan's redefinition or modification of their terms regarding the length of the initial enrollment period or its assumption of commencement of coverage under Medicare B at the earliest time when those plans use only the phrase "when eligible for primary Medicare coverage" to advise their participants of the duty to enroll?

OR

(2) Require a State group health insurance plan to extract a

specific waiver, consciously and voluntarily consented to, from each such participant, acknowledging that the State's group health insurance plan has both shortened the length of the initial enrollment period for Medicare B and has insisted upon the commencement of Medicare B coverage as of the earliest possible date under §1395 q, in order to make the plan's medical insurance coverage secondary to Medicare B at that earliest time?

N.B. The Courts below have ruled that these federal statutes neither bar the insurer's *assumption* of its participants' commencement of Medicare B coverage at the earliest possible date, nor require any specific notice or waiver of their terms from group health insurance plan participants at the time when they first become eligible for Medicare B coverage at age 65.

SUBSIDIARY QUESTION: Whether the process of incorporating Medicare B as the primary payor under a State Employees Group Health Insurance Plan is controlled by Federal or by State laws and regulations, or by both, where not inconsistent? Specifically, in this case, whether the scope of the notice advising participants of the way Medicare B is integrated into the Health Plan is a substantial federal question?

II.

Subchapter XX of Title 42 of the United States Code, §§ 300 bb-1 through 300 bb-8 establishes requirements for Group Health Insurance Plans for State and local government employees. Its essential feature is to mandate that "as to each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event, he then(becomes) entitled, under the Plan, to elect, within the election period, *continuation coverage* under the plan." See 42 U.S.C. §300 bb-1, subparagraph (a).

42 U.S.C. 300 bb-2 subparagraph (2)(A) provides for a maximum required period of time of 18 months for "*continuation coverage.*" The statute, however, does not forbid

voluntary periods of time, beyond 18 months, for *continuation coverage*.

42 U.S.C. 300-bb-2, subparagraph (2)(D) authorizes a State health plan to end *continuation coverage* on the date on which the beneficiary first becomes: "(ii) entitled to benefits under Title XVIII of the Social Security Acts (42 U.S.C., §1395 et seq.)"

42 U.S.C. 300 bb-3 defines "qualifying event." Subparagraph (2) of that section states that the covered employee's termination of employment is a qualifying event.

First Question: Do the terms of Title 42 U.S.C. 300 bb-2 subparagraph (2)(A) imply that federally mandated continuation coverage automatically ends 18 months after the qualifying event, and the federal statute thereafter becomes inapplicable for all purposes, or may a State group health insurance plan extend continuation coverage beyond the 18 month period, thereby waiving its right to terminate continuation coverage at that time, in which case, do the subsequent statutory provisions in § 300 bb-2, subparagraph (2) continue in force? Cf. Oakley v. City of Longmont, 890 F.2d 1128 (10th Cir. 1989) at p. 1132, which holds that termination after 18 months is *automatic*.

Second Question: In the face of such federal statutory provisions, can New York State authorize the termination of primary medical insurance *continuation coverage* "as of the first possible Medicare B effective date a NYSHIP (New York State Health Insurance Plan) participant can have under the federal rules" regardless of whether the participant is entitled to Medicare benefits on that date, and based solely on his eligibility for Medicare B at that time?

Or, must such continuation coverage remain in force until, as §300 bb-2, subparagraph (2)(D)(ii) provides, the participant has become "entitled to benefits" under the Medicare Acts?

Third Question: Moreover, can a State authorized group health

insurance plan create a six month gap in primary medical insurance *continuation coverage* as a consequence of its statutes, assumptions, and administrative regulations - a gap which petitioner herein has experienced to his financial damage, or does the plain Congressional intent of subchapter XX forbid creating such a gap in coverage? Cf Teweleit v. Hartford Ins. Co. 43 F.3rd 1005 (5th Cir.1995) at p. 1008-1009, which holds that the purpose of COBRA coverage is to "eliminate gaps in insurance coverage that could accompany changes in, or loss of, employment."

III.

Title 42 U.S.C. §300 bb-6 establishes the notice requirements a state group health insurance plan must provide to each covered employee at the time of commencement of coverage under the plan. The notice must advise the employee of his "rights under this subsection (i.e.. subchapter XX)."

Question: Did the notices in this Record comply with the provisions of 42 U.S.C. §300 bb-6? Specifically, did the notices advise that termination of continuation coverage after 18 months was automatic? Did the notices advise that termination of primary medical coverage would occur at the earliest possible date under the federal rules, based on an assumption of enrollment at that time of eligibility?

IV.

Question: Does the Complaint Petitioner filed herein on his own behalf, and on behalf of a class of approximately 250 other participants in NYSHIP, state a cause of action under the federal statutes it recites upon which the relief the Complaint demands ought to be granted? See 42 U.S.C. §300 bb-7. And can petitioner bring a class action to enforce such a cause of action on behalf of a group?

V.

In view of the findings of the trial court that "(petitioner) never

lost his insurance coverage [illegible] rather it became secondary to Medicare B when he reached [illegible]e 65" (See Appendix at p. A-8); which findings the Appellate Division has now affirmed, and in view of Rule 73.2 of the New York Department of Civil Service, have the Courts below, as a matter of law, determined that NYSHIP has violated the terms of the Medicare as Secondary Payor Act. 42U.S.C. 1395y, subparagraph (b)?

(b) The Parties

The parties herein are as listed in the caption of the Petition.

The affiliates of Metropolitan Life Insurance Co. and United Healthcare, Inc. are as set forth in the appendix attached hereto at pp. A-95-A-105. The Respondents have provided this information in papers filed in the Court below. Petitioner has no first-hand knowledge of their accuracy.

(c) Table of Contents

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(d) Citations to the Reports of the State of New York of the Opinions and Orders Entered in this Case by the Courts Below

Regan v. Department of Civil Service, etal.
Citation: 2001 W.L. 633624
2001 N.Y. Slip 5112
284 A.D.2d 950 (4th Dept. 2001)
(New York Appellate Division Reports Second Series)
Lower Court opinion unreported.

(e) Statement as to the Jurisdiction of the Supreme Court of the United States

In accordance with subparagraph 1. (e) of Rule 14, petitioner supplies the following facts:

The Order sought to be reviewed was entered in this Case on June 8th, 2001 by the Clerk of the Appellate Division of the Supreme Court of the State of New York, Fourth Judicial Department.

The Order of the Appellate Division was subject to discretionary review by the Court of Appeals of the State of New York, the Court of last resort in New York.

Petitioner moved for leave to Appeal to the Court of Appeals on July 3rd, 2001.

The Court of Appeals entered an Order denying the motion to grant leave to appeal on September 20th, 2001.

No motion for rehearing has been made.

The statutory provision which confers jurisdiction on this Court to review the order of the Court below by writ of Certiorari is Title 28 United States Code §1257 (a).

(f) THE STATUTORY & CONSTITITIONAL PROVISIONS INVOLVED IN THE CASE

N.B. In accordance with Rule 14, 1(f), and due to the length of the texts of the federal and state statutes, and the state regulations involved in this case, the pertinent texts are set out in the Appendix attached hereto at pp. A-75 through A-94.

	Page No.
1. 42 U.S.C. 1395 p.	A-75
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CONSTITUTION OF THE UNITED STATES:

Article VI

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Paragraph 2

...This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made or which shall be made, under the Authority of the United States

shall be the Supreme Law of the Land; and the Judges in every State shall be bound thereby; any thing in the Constitution or laws of any State to the contrary not withstanding.

(g) STATEMENT OF THE CASE

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Petitioner's original Complaint, dated December 30th 1997, was filed, together with its annexed summons, in the Supreme Court of the State of New York, Monroe County (Rochester), on January 6th, 1998. The Complaint alleged, in respect to the Respondents herein, New York State Department of Civil Service, Metropolitan Life Insurance Co., and United Healthcare Corporation, four separate and distinct causes of action. They were as follows:

Action No. (1): A claim that the regulations and the provisions, including the language in the insurance certificate, constituting the terms of the New York State Health Insurance Plan (NYSHIP) which the Department of Civil Service had approved and implemented with the Respondents, Metropolitan and United Healthcare, known as the Empire Plan, were contrary to, and inconsistent with, the provisions of Title 42 U.S.C. 1395 p & q, and that plaintiff had not waived his federal rights thereunder, and that, accordingly, they were void and ineffective as to their assumptions of his coverage of Medicare B.

Action No. (2): (Solely a claim under New York State Laws)

Action No. (3): (Solely a claim under State Law and the common law of third party contracts).

Action No. (4): A claim that the practice of Respondents, Metropolitan, United Healthcare, and Department of Civil Service, which, for purposes of making Medicare B the primary payor for participants in the Empire Plan, assumed that commencement of coverage under the Medicare B statutes had occurred for each participant as of the earliest possible date under the provisions of 1395 q, regardless of whether the participant had, in fact, enrolled in Medicare B during the initial enrollment period, at a time early enough to accomplish coverage as of that earliest possible date, was a violation of the provisions of subchapter XX of Title 42 U.S.C. §300 bb-1, et

seq., specifically, 42 U.S.C. 300 bb-2, subpar. (2)(D)(ii).

Accordingly, petitioner raised the federal questions as to which he seeks review in this Court at the very outset of this civil action, to wit, at the time he filed his summons and complaint. A copy of the petitioner's complaint appears in the Appendix at pages A-13 through A-48.

The court of first instance was the only court to express an opinion, and to pass upon, these federal questions, in an expository written statement. That written opinion appears in the Appendix at page A-1 through A-8.

As to the first cause of action, the Court held that the State's only obligation to the petitioner was to "adequately notify him of the requirement that he enroll in Medicare Part B prior to his 65th birthday." The Court went on to hold that the Notices in the record were adequate for this purpose. The Court ignored defendant's Department of Civil Service admissions in the Affidavit of Christine Williams, its employee, that:

(1) Under NYSHIP rules, those who are eligible for Medicare Part B must enroll to avoid reduced health insurance coverage, because NYSHIP benefits become secondary based on an individual's eligibility for Medicare Part B, not on their actual enrollment in it. Appendix p. A-62

and

(2) The NYSHIP underwriting control assumptions for the Empire Plan have included an assumption that NYSHIP will become secondary payor to Medicare as of the first possible Medicare effective date a NYSHIP enrollee can have under the federal rules which is...the first day of the month in which his 65th birthday occurs. Appendix p. A-65-A-66

Moreover, the Court ignored petitioner's contentions that it was a question of federal law whether a NYSHIP enrollee had waived (and adequacy of notice is a waiver issue) his right to

enroll in Medicare B at any time during the initial enrollment period in order to comply with NYSHIP assumptions as to coverage under Medicare B as of the earliest possible date, and its notices to enroll "when first eligible".

As to the fourth cause of action, the Court held that subchapter XX of Title 42 did not apply to the petitioner. This conclusion of law notwithstanding, the following facts are not controverted in this case:

(1) Petitioner was a State employee, enrolled in NYSHIP, for over ten years from 1982-1992.
(2) Petitioner left State Judicial office honorably in January, 1992 at the end of his elected term.
(3) Petitioner would have lost his NYSHIP medical insurance coverage in January 1992 had he not exercised his rights under State Laws, to continuation coverage. N.Y. State Civil Service Law, §165, subparagraph 1.
(4) State law did not terminate petitioner's continuation coverage at the expiration of 18 months, as allowed in §300 bb-2, but authorized indefinite continuation so long as petitioner paid the premiums. N.Y. Civil Service Law §163, subparagraph 3, also Rule 73.2(a)(3).

All of which meant that N.Y. State law had complied with the provisions of Title 42 U.S.C. §300 bb-3, subparagraph (2) §300 bb-5, subparagraphs (1) and (2); and §300 bb-1. It is significant that the federal law only requires that the qualified beneficiary "would lose coverage under the plan as a result of a qualifying event" not, as the Court below stated, that an enrollee "must first lose insurance coverage due to ... the termination of employment." It is true petitioner did not lose insurance coverage after he left office because he properly exercised his rights under State law to "continuation coverage" as the Federal statute required. See Opinion of the Court, Appendix at p. A-8.

* * *

* * *

There are no material facts in dispute in this case. The petitioner elected to continue in NYSHIP Empire Plan's medical insurance after he left state office in 1992. He made all his insurance premiums payments thereafter. (R. pp. 356-357). He became 65 years of age on April 18th, 1997, his date of birth being April 18, 1932. He applied for Medicare B in July, 1997, within his initial enrollment period.

From early 1992, when petitioner left State Judicial office, until the end of 1997, petitioner served as a County Attorney for Monroe County (Rochester) New York. He remained an employee of a political subdivision of New York State throughout the entire relevant time period alleged in the Complaint. The County, however, had a different group health insurance plan, so the petitioner chose to exercise his right to continue his coverage under NYSHIP.

In August 1997, petitioner was diagnosed with rectal carcinoma. Petitioner received medical and surgical services at Roswell Park Cancer Institute in Buffalo. Respondents refused to pay that part of petitioner's medical bills which Medicare B would have paid if it had been in effect - approximately $15,000; they paid only what was due over and above that sum. Petitioner's continuation medical coverage under NYSHIP went from primary to secondary on April 1st, 1997 under NYSHIP rules and assumptions. Petitioner's Medicare B coverage commenced October 1st, 1997, as §1395 q provides since he enrolled in Medicare in July 1997. There was, accordingly, a six-month gap in primary medical insurance coverage, during which time period petitioner incurred substantial medical expenses. Petitioner alleges money damages as a result of that gap in primary coverage.

Furthermore, petitioner seeks to represent a class of about 250 other participants in NYSHIP. Respondents admit that from1992-1997, inclusive, approximately 188 other members were denied primary medical coverage because of a failure to

enroll promptly in Medicare B. This figure translates into about 31 claims a year. Consequently, as of January, 2000, Respondents had denied 250 claims from NYSHIP participants over the previous eight years[1].

Finally, both Courts below ignored petitioner's arguments that NYHIP had failed to comply with the notice requirements imposed on NYSHIP by 42 U.S.C. §300 bb -6.

The Appellate Division - the Court to whom petitioner has sought the issuance of this Writ of Certiorari - merely affirmed, unanimously, the opinion of the Court of first instance "for the reasons stated in the decision at Supreme Court, Corning, J." The order of affirmance is dated June 8th, 2001.See Appendix, at p. A-9, A-10..

Petitioner moved for leave to appeal to the N.Y. Court of Appeals, the Court of last resort in N.Y. State, on July 3rd, 2001. That Court denied the motion, by order, on September 20th, 2001. See Appendix at p. A-11, A-12.

Under Rule 13, subparagraph 1, this petition is timely if petitioner files it on our before December 19th, 2001.

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[1] Respondents in January 2000, published a revised set of notices to its participants in its insurance certificate. Under State law, the revised notices end the class affected by the former notices.

(h)Argument specifying the Reasons for Granting the Writ

Rule 10 lists three general propositions for persuading this Court to grant a petition for a Writ of Certiorari. Neither subparagraph (a) nor (b) of that Rule applies to this case. Only the proposition that the Courts below, and certain Courts of Appeal, have decided an important question of federal law that this Court should settle applies to this Case.

The fact, however, is that the Courts below have utterly ignored the federal statutes the petitioner has invoked, or have decided, wrongly, that they do not apply.

Members of this Court - principally the Chief Justice - have permitted television interviews on C-Span over the years which have delved at length into the internal process the Court uses to decide whether to grant the petition. It is not enough, says the Chief Justice, that the Courts below have wrongly decided the case. Were that the template, the Court's calendar would have no end. More is needed. There must be an important question of federal law to clarify or to settle.

Of course, what can be gleaned from these principles is actually a two-fold guideline. First, the Court will never grant the Writ if the Court below has decided the case correctly. Second, this Court must be persuaded that in deciding the case incorrectly, the Courts below have trampled upon federal laws in an egregious and unpardonable manner so significantly as to "call for an exercise of this Court's supervisory powers" or that they have dealt erroneously with an important question of federal law that this Court should settle to the contrary. Petitioner will now argue that the latter principles exist in this case.

(1) The Decision Below is egregiously erroneous
(1) §1395 p. and q.

Respondents have successfully argued below that their insurance certificates informed the petitioner that he must enroll in Medicare B prior to his 65th birthday and have coverage in effect

at the earliest possible date under the federal rules. They scoff at petitioner's contention that a State cannot, by statute, regulation, or group health insurance plan, abbreviate the seven-month initial enrollment period of §1395, which that federal statute grants to individuals when they attain age 65. They assert that the Plan's certificate does not shorten the period, it merely eliminates the Plan's primary medical insurance coverage as of the earliest possible Medicare effective date under the federal rules. Petitioner replies that the advisory to enroll "when first eligible" is insufficient as a matter of law to deprive an enrollee of his federal statutory right to enroll at any time during the initial enrollment period.[2] Moreover, petitioner claimed that how a state-authorized group health insurance plan compelled Medicare enrollment, and entitlement to Medicare B benefits, to become effective at the earliest possible date, was primarily a question of federal law, not State law.

One of the notices appears in the Court's opinion (at Appendix p. A-7). It states:

> "If you are no longer an active employee, contact your local social security office three months before you or your spouse turns age 65, to arrange for enrollment in Medicare Parts A & B. Once you or your spouse has enrolled, Medicare coverage becomes effective on the first day of the month in which you reach age 65."

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[2] The notices which respondent supplied to its participants in NYSHIP are subject to two statutes one State and one Federal. The Courts below have held that under Section 162, subparagraph 5 of the N.Y. Civil Service Law, the advisories in the Certificate to enroll in Medicare "when first eligible" convey information to each participant sufficient to tell him to have Medicare B in effect on the 1st day of the month he turns 65. That statute, accordingly, is no longer an issue in this case as its interpretation is solely a question for State law. Interpretation of the Federal statute is, however, the prerogative of this Court. Title 42 U.S.C. 300 bb-6 requires respondents to advise beneficiaries of their "rights under this subsection (subch. XX)". In that regard, the notices in the Certificates are inadequate as a matter of law.

Respondents have succeeded in persuading the Courts below that this notice is adequate to inform petitioner that he:

(1) MUST enroll in Medicare B during the first three months of his initial enrollment period, and not afterwards.
(2) MUST have Medicare B in effect on the 1st day of the month he turns 65
(3) WILL LOSE primary medical insurance coverage under NYSHP on the 1st day of the month he turns 65 regardless of whether he has enrolled by then in Medicare B.

But, of course, the notice does not even mention the initial enrollment period of seven months' duration, the documentation required for enrollment, nor the variations in the effective dates of Medicare B coverage depending on when enrollment occurs, nor does it advise that primary medical insurance coverage under NYSHIP will end under the plan on the earliest possible effective date under the federal rules regardless of whether enrollment and/or entitlement to Medicare benefits has occurred by that time. Therefore, what the notice states is true ONLY for Medicare A, not Medicare B, because enrollment at any time during the initial enrollment period relates back to the 1st of the month one turns 65 only for Medicare A.

Moreover, the petitioner, when he turned 65, was in NYSHIP under his federal statutory right to continuation coverage. Termination of continuation coverage - and elimination of primary medical coverage, is a termination - can occur under §300 bb-2, subparagraph(2) (D)(ii), only after a qualified beneficiary has become "entitled to benefits under Title XVIII." (42 U.S.C. §1395 et seq.) But that part of Subchapter XX of Title 42 was ruled inapplicable, and was ignored.

Finally, petitioner was an active employee at the time he turned 65, working for a political subdivision of N.Y. State, to wit, the County of Monroe (Rochester). Moreover, under N.Y. Civil Service Rules, §73.2, subparagraph (a), his status "as an

employee is deemed to continue" while he is a vestee. Accordingly, under those State statutes and regulations, he was an active employee, and was within the meaning of the definition of "active employee" under the Medicare as Secondary Payor Act, 42 U.S.C. 1395 y, subparagraph (b)(1)(A)(i)(I) and (II), and subparagraph (b)(1)(E)(ii). That statute forbids shifting primary health insurance coverage from the private insurance carriers to the Medicare program for participants in petitioner's class, who have retained, under State law and regulations, their status as employees[3].

(2) 42 U.S.C. §300 bb-1 through §300 bb-8; 42 U.S.C. 1395 y, subpar(b)

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What is not in dispute in this case is that NYSHIP was obliged to provide some form of medical insurance coverage to petitioner, Respondents claim that coverage was secondary to Medicare. Petitioner claims it was primary and Medicare was secondary.

The Court below held that:

> "In order to utilize the provisions of COBRA, an insured must first lose insurance coverage due to a certain enumerated event, such as a termination of employment, or the death of a covered spouse. See 42 U.S.C. 300 bb-1. Plaintiff here can point to no such qualifying event. His insurance coverage was never lost, but, rather, it became secondary to Medicare Part B when he reached age 65. Hence, he cannot make an argument that the provisions of COBRA were violated in his case, as these provisions do not even apply to his case." See Appendix at p. A-8

If what the Court held is the truth and the original coverage still

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[3] Probably, but not certainly, the Medicare as Secondary Payor Act, applies to large group health insurance plans operated by State and Federal governmental agencies since 26 U.S.C. 5000, subpar(d) is inapplicable under title 42 U.S.C. 1395y, subparagraph(b)(1)(i)(v), p A-78

existed then NYSHIP has violated the provisions of the Medicare as Secondary Payor Act, 42 U.S.C. 1395 y, subparagraph (b)(1)(A)(i) which forbids discriminating between those 65 and older, and those younger than 65, who have health insurance coverage by virtue of their similar "current employment status with their employer". N.Y. Civil Service Rules 73.2, subparagraph (3) does continue Petitioner's status as an employee of N.Y. State, for this purpose.

But if, as the facts admitted herein prove, Petitioner was exposed to a risk of losing his NYSHIP medical coverage when he left judicial office in January, 1992 (See N.Y. Civil Service Law, §165, subparagraph 1), unless he chose to continue such coverage and pay the premiums therefor, which he did do, then that event was a "qualifying event" under 42 U.S.C. §300 bb 3, and accordingly, all the provision of subchapter XX of Title 42 applied to the Petitioner. This is the petitioner's contention and it presents a federal question this Court should settle.

Certainly the Court below erred when it held this statute did not apply to petitioner. At the expiration of his elected term, in 1992, petitioner left State judicial service under honorable conditions. Cf. Larsen v. Senate of Comm of Pa, 154 F.3rd 82 (C.A. 3rd 1998). That triggered the provisions of §300 bb-3, subpar. (2) regarding termination of his employment as a qualifying event. His election to continue in NYSHIP under State laws and regulations (N.Y. Civil Service Law §163, subpar. 3) was an exercise of his federal statutory rights. Since petitioner paid the NYSHIP premiums, throughout the following years, his coverage continued, and is still in effect at this time, the State of N.Y. having waived its federal statutory right to limit coverage to 18 months.

The only change in those years (1992-2001) in Petitioner's NYSHIP continuation coverage was the reduction to secondary payor status for NYSHIP when petitioner enrolled in Medicare. But that reduction occurred before petitioner was entitled to the benefits coverage under Medicare B, and it was NYSHIP's policy to effect the reduction to secondary payor status based on

the Medicare eligibility of its participants not on their entitlement to Medicare benefits. See Affidavit of Christine Williams for Respondent Department of Civil Service, par 20. Appendix at p. A-62.

NYSHIP's policy is a direct violation of Subchapter XX of Title 42 of the United States Code, section 300 bb-2, subparagraph (2)(D)(ii) which forbids ending any part of continuation coverage prior to the date the qualified beneficiary becomes entitled to Medicare benefits.

The Court should pay particular attention to the phrase "entitled to benefits" in §300 bb-2(D). As originally drafted in 1986, this phrase read "eligible for benefits". However, in 1989, Congress amended the section to delete the phrase "eligible for benefits" and it substituted "entitled to benefits". See 1989 Stat. 101-239.

Also, by statutory definition, in a termination of employment event, the covered employee (petitioner) is a "qualified beneficiary". See 42 U.S.C. 300 bb-8, subparagraph (3)(B).

* * *

The most important federal issue in this case does not surface in the Record because the Respondents never raised it, and because the Court below held that subchapter XX did not apply since the petitioner never lost his insurance coverage, it was only reduced to secondary payor status.

As to the lower Court's reduction of benefits finding, the federal statute is clear. Continuation coverage must be identical to the coverage provided under the plan as to participants who have not experienced a "qualifying event." §300 bb-2, subpar. (1). That means primary medical coverage and nothing less. Secondary payor status or full termination of coverage can occur only after a qualified beneficiary becomes entitled to Medicare benefits. §300 bb-2, subpar. (2)(D)(ii). Moreover, it is not necessary to lose insurance coverage in order to come under the protection of subchapter XX. It is only necessary that the

qualifying event triggers a risk of loss of such coverage. See N.Y. Civil Service Law §165, subpar. 1.

The major issue is the question of 18 month's duration of continuation coverage. In Oakley v. City of Longmont 890 F.2d 1128 (C.A. 10th 1989) that Court held:

> "We turn to the subsection at issue in this appeal, 42 U.S.C. §300 bb-2(2), the period of continuation coverage. Continuation coverage automatically terminates after the maximum period of coverage permitted, 18 months from the date of the qualifying event." See 890 F.2d at p. 1132.[4]

Under New York Law, persons in petitioner's situation are entitled to continue participation in NYSHIP indefinitely, so long a they continue to pay their medical insurance premiums. At the time petitioner elected to continue under NYSHIP Empire Plan (1992) the Respondents did not, indeed under State Law could not, notify him that his continuation coverage would end after 18 months. §300 bb-6 would mandate such a notice if that were the case. Accordingly, continuation coverage extended beyond the mandatory 18-month period.

In the Courts below, petitioner argued that any State can provide continuation coverage voluntarily beyond 18 months as New York has done. In that event, the other sections of §300 bb-2 continue in force so long as the notices required under §300 bb-6 are issued to that effect. What that means in this case is that the NYSHIP notices had to tell participants in the plan that medical coverage would become secondary when they became "entitled to Medicare B benefits[5]." And, certainly, the NYSHIP plan could not end primary coverage upon an assumption of the participant's entitlement to Medicare B, at the earliest possible

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[4] Compare however the same Court's language on p. 1131: "...coverage must extend for at least eighteen months from the date of the qualifying event." 890 F.2d 1128, at p. 1131.

[5] 42 U.S.C. 300 bb-2, subpar(2)(D)(ii).

date under §1395 q.

Moreover, on the question of adequate Notice, petitioner's efforts to draw the attention of the Courts below to comparable federal cases under ERISA, e.g. Layou v. Xerox Corp. 238 F.3rd 205(2nd cir. 2001) and Santana v. DeLuxe Corp. 12F. Supp2d 162, (U.S.D. Ct. Mass. 1998), a comparison federal Courts of Appeals have corroborated, (Oakley v. City of Longmont, 890 F.3rd 1128 at p. 1131), were to no avail whatsoever. Notices under §300 bb-6 and summary plan descriptions under 26 U.S.C. 1022, function exactly as §300 bb-6 demands, and these ERISA cases were pertinent on that question.

(3) The Record Raises Important Questions of Federal Law that this Court should clarify and settle.

Virtually every section of subchapter XX of Title 42 of the United States Code is implicated in this case. The questions are:

1. Whether the provisions of the federal statute continue after expiration of the 18-month mandatory period, when the State voluntarily extends the period of continuation coverage beyond 18 months.
2. Whether a change of medical insurance coverage from primary to secondary is a "termination" of coverage under §300 bb-2.
3. Whether a group health plan for any State may effect a "termination" of primary medical coverage upon an assumption that Medicare B has become effective for its participants" as of the earliest possible date the participant is eligible under the federal rules, regardless of whether Medicare B is in effect and the beneficiary "entitled to benefits" at that time.
4. What are the essential contents of the notices §300 bb-6 requires at the commencement of continuation

coverage?

5. Whether §300 bb-7 authorizes this action for equitable relief to be brought in a State Court, as a Class action.

Moreover, the questions pertaining to the process of relinquishment of the federal rights conferred on individuals turning 65 years of age under §1395 p. and q. of Title 42 as to their enrollment in the Medicare program, and substitution of Medicare as the primary payor under a State group health insurance plan, are also presented to the Court, as are the proscriptions contained in the Medicare as Secondary Payor Act.

* * *

There are millions of senior U.S. citizens becoming Medicare eligible and dependent every year. Medicare is the largest single item in the domestic federal budget.

This case - and this Court's decision if certiorari is granted - will affect the group health plans of every present State's, and its political subdivision's, employees in the nation. And it will both impact on the Medicare budget, and on the duties of health insurance carriers for all State and local government employees enrolled in their group health insurance plans.

The statutes involved here have received little judicial attention. Individual violations of their provisions usually involve minor amounts of money, so litigation about them is sparse. This case is a rare exception to that otherwise general rule. But the widespread importance of these statutes is undeniable.

CONCLUSION

Petitioner prays that the Court grant the Writ.

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